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FOR THE AWARD OF DEGREE OF

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EMOTIONAL INTELLIGENCE, EMPATHY AND CLINICAL ANGER IN DOCTORS WORKING IN A TERTIARY CARE HOSPITAL

BY

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MY THESIS

IS DEDICATED TO

MY WIFE Dr. MONIKA,

& MY CHILDREN LUVYA

& SHOURYA.

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I submit this Thesis of mine with great humility and utmost regard.

(Dr. Ram Mehar Sheoran)

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INTRODUCTION

INTRODUCTION

Emotional awareness and the ability to respond appropriately to one's own and other people's feelings are the two components that make up emotional intelligence (EI). EI may be broken down into two different fundamental concept models, which are Ability EI and, Trait & Mixed EI. Mayer and Salovey's definition of emotional intelligence (EI) is the capacity to recognize and integrate emotion, as well as the ability to grasp and control emotion in order to support human development[1].

The evaluation is done via the submission of answers to performance-based questions. Trait EI, as described by Petrides and Furnam[2,3], and Mixed EI, as defined by Golemann[4], may be viewed as a collection of interrelated competencies, skills, abilities, personal qualities, and personality traits. These definitions were found in two separate studies. The self-perception of an individual's emotional self-efficacy is evaluated using Trait emotional intelligence (EI). Even if the notion is evaluated in a variety of ways, sample domains are comparable to one another. Both of these schools of thought see emotional intelligence (EI) as a multifaceted notion that includes both cognitive and affective aspects, such as the capacity to recognize, deal with, and use emotional information in one's day-to-day decision-making and behaviour[5].

The Trait EI evaluation, also known as the TEIQue (Trail Emotional Intelligence Questionnaire), may give essential and consistent cross-situational information about an individual's personality and behavior[2]. A higher level of EI has been shown in studies to improve the patient-physician connection, collaboration and communication skills, stress management, organizational commitment, leadership, and academic success[5].

Emotional intelligence may be defined as the ability to manage and postpone the demands of another person, to regulate the emotions of others, to separate emotion from rationality, to put oneself in the shoes of another, and to hope. In addition to this, it includes a range of skills, such as the capacity to exercise self-control, persistence, enthusiasm, and the ability to motivate other people[6].

According to Daniel Goleman(1998)[7], emotional intelligence comprises of self-awareness, empathy, relationship management, emotion management, and motivation. There is no one number that can adequately describe the breadth of human ability; nevertheless, these skills may be broken down into the following five categories[7]:

- Conscience, or the ability to identify an emotion the instant it arises, is the foundation of emotional intelligence. Knowing our sentiments is an essential component of this

skill. The capacity to comprehend and value our feelings is essential to gaining psychological insight and developing an awareness of one's own personality.

- The capacity to shape and control our feelings in such a way that they are suitable at any given moment is a skill that is founded on consciousness. Those who lack this skill constantly struggle with emotions of sadness, whilst those who are recognized for possessing it have a greater capacity to rapidly recover from the failures and let-downs that are inevitable in life.
- Exploration of incentives: Having control over one's emotions in such a way that they may be directed toward the achievement of a goal is needed in order to concentrate one's attention, discover incentives, have self-possession, and be creative. It seems that self-control over one's emotions is the key to success in any endeavor. People that possess this skill are often far more effective and productive than their peers.
- Recognizing the feelings of other people is an essential component of the "human talent" known as empathy. This is because empathy is built on a foundation of emotional awareness. People who are empathic are more open to ignoring social cues that indicate what the wants and needs of other individuals may be[8]. Because of this, people who are empathic tend to do better in careers that include community outreach, teaching, sales, and administration.
- Handling relationships: The ability to handle other people's emotions is a big part of what makes the art of interpersonal connections so difficult to master. These are the abilities that contribute to popularity, leadership prowess, and success in interpersonal interactions. People who have such talents to a significant degree stand out in terms of their ability to engage naturally with people and always differentiate themselves in social settings.

An additional facet was introduced in the early 1990s by Howard Gardner's research on the concept of "multiple intelligence." Following this was Reuven Baron's idea on emotional intelligence, which led to the development of the term EQ as an alternative to IQ[9].

According to Reuven Baron, emotional intelligence is associated to a person's capacity to know oneself and others, rapidly adapt to changes and demands of the environment, and manage emotions. [Citation needed] It is true that the many psychometric tests used to evaluate emotional intelligence are still relatively new in the field of psychometrics. Measuring such complex elements may be difficult and time consuming, which might lead to surprising results[9].

The researchers that looked into the connection between emotional intelligence and academic success discovered a correlation between the two that was not quite as strong as others. The school is responsible for instilling in the students the ability to achieve their goals, to experience joy, and to participate in exciting activities. All students, regardless of whether or not they excel in their studies, are subject to the aforementioned requirements. It is a common misconception that the educational system in place today has focused all of its attention and energy on the achievement of cognitive goals. It is important to recognize, without diminishing or discounting the relevance of these goals, that this strategy, which is unilateral, often damages mental health, internal balance, and peace for all parties affected[9].

In the 1880s, a German psychologist by the name of Theodore Lipps used the concept "einfuhlung" (literally translated as "in-feeling") to describe the emotional awareness of the feelings of another person. This is when the term "empathy" was first used. The act of grasping the subjective experience of another person by vicariously experiencing that experience while maintaining vigilance is one definition of empathy. Another definition of empathy describes it as the state of having empathy for another person. It would seem that the capacity for empathy is very necessary in the therapeutic relationship[10].

Empathy is the capacity to understand the feelings of other people, as well as the motivations behind those sentiments, and to share in another person's emotional experience without taking on those feelings oneself. Gagan JM eat al.[11] defines empathy as the ability to be aware of one's own feelings while also being able to communicate those feelings to other people. It is important for medical professionals and patients to interact with empathy in order to achieve the therapeutic outcomes that are desired[12]. Because there seems to be a great deal of room for interpretation about the particular idea of "empathy," it has been determined that more investigation into this concept is required in order to make its meaning clearer.

The capacity to feel sympathy was assigned to the first concept by Fairbairn (2002)[13], who was explaining the contrasts between sympathy (pity) and empathy (empathy). Empathy was defined as the ability to put oneself in the shoes of another as a sign of humanity. Sympathy was defined as the capacity to feel sympathy. When a person puts himself in the shoes of another individual and tries to empathize with them, they experience a wave of overwhelming emotions known as sympathy. Empathy, on the other hand, is a skill that can be developed or a way of life that one may adopt in order to connect with another person, engage in conversation with them, and understand the feelings or experiences that they are going through[14].

In addition, the degree to which a person feels responsible for the welfare of others may be used as an indicator of whether or not they have highly developed empathy and whether or not they are more likely to make use of this ability in their daily lives. Empathy may be used to portray a wide range of emotions, including pleasure, sadness, excitement, pain, and even bewilderment. It is possible for medical professionals and patients to work together on treatment thanks to empathy. It is sometimes described as "the capacity to view the world through the eyes of another," which, in essence, means gaining the ability to envision what another person is thinking and experiencing in a specific scenario. This is sometimes referred to as the "capacity to view the world through the eyes of another." This is an effort on both of our parts to better understand one another by sharing the same experiences and emotions. When attempting to understand and share another person's experiences via empathy, it may be challenging to get a clear picture of those feelings. However, it is essential for medical professionals to make an effort to imagine what it is like for their patients and try to empathize with them[15].

There are a variety of mental abilities that can be utilized at each of these stages, including searching for and selecting the patient's qualifications, careful monitoring and hearing, using additional questions for gathering information to specify dark spots, providing the patient with small encouragements (such as a head nod, simple words, or cues), directing the patient to possible solutions, and supporting his efforts to change. A study that was conducted not too long ago and published in the journal "Science" discovered that humans are not the only species in nature who are capable of empathy. Researchers at McGill University in Canada let mouse couples gaze at one other while one of the animals was being painfully stimulated. During this time, the other mouse in the partnership was in agony. They were taken aback when they saw a statistically significant behavioral change in the mouse-level observer's of discomfort[16].

The accumulation of life experiences does not give rise to empathy. It is the moment when people interact with one another in a manner that is considered "nonverbal." What really important is the desired and actual amount of empathy that is generated. Personality has a role in the patient-physician interaction as well as in the treatment of patients, in addition to emotional intelligence and empathy. Recent studies have shown that EI and empathy are related to personality traits in medical students, as well as to their potential to become successful physicians.

AIMS AND OBJECTIVES

AIMS & OBJECTIVES:

AIMS:

TO ASSESS EMOTIONAL INTELLIGENCE, EMPATHY, AND CLINICAL ANGER IN DOCTORS WORKING IN A TERTIARY CARE HOSPITAL.

OBJECTIVES:

THE OBJECTIVES OF THE STUDY ARE TO-

- TO ASSESS EMOTIONAL INTELLIGENCE AMONG DOCTORS FOCUSING SPECIFICALLY ON EMPATHY.
- TO ASSESS THE LEVEL OF CLINICAL ANGER.
- TO CORRELATE THE LEVEL OF CLINICAL ANGER WITH EMOTIONAL INTELLIGENCE AND EMPATHY IN DOCTORS.

REVIEW OF LITERATURE

REVIEW OF LITERATURE

Over 70% of medical postgraduates who took part in the study titled "Study of emotional intelligence and empathy in medical postgraduates" by Abhijeet Faye et al.[17] exhibited low emotional intelligence (On Emotional Quotient Self-Assessment checklist). In this study, married men exhibited greater self-assurance and empathy. People who had significant problems at home were more sensitive to their own emotions and those of others. Residents who had chosen their speciality post-graduate training programme willingly (such as those in medicine, surgery, and other fields), had a lighter workload, and had more free time for leisure activities and exercise had performed well on the EI.. Good control of emotions in self was associated with good relationship with superiors and colleagues. Score on Clinical anger was moderate to severe in 10.6% of the subjects. EI and clinical anger correlated negatively. It concluded that Factors correlating with good EI were: Male subjects, Less work hours (10–30 h/week), Good sleep (50–60 h/week), Good relations with superiors and colleagues, Married residents, Attendance in at least one Communication Skills Workshop and factors correlating with poor EI were high level of Clinical Anger, More work hours (>50 h/week).

Leila Karimi et al.[18] in their study titled "Emotional intelligence: predictor of employees' well-being, quality of patient care, and psychological empowerment." found that emotional intelligence is related to all three variables in a statistically significant but moderate way. Both psychological empowerment and quality of care were significantly related to EI skills. Well-being was significantly predicted by EI skills. This study shows that those with a high level of EI are possibly more psychologically empowered. The results also suggest that if EI is related to employees' well-being, empowerment, and quality of care, then implementation of interventions for employees in the healthcare sector to learn and practice EI skills seem to be valuable for employee empowerment and consequently for enhancing employees' performance. Evidence also shows that EI impacts ethical decision-making, critical thinking, evidence, and knowledge use in practice. The study also provided evidence for a significant association between EI and the well-being of employees, demonstrating that staff with higher EI are more likely to have better emotional and psychological wellness. Finally, the findings indicate that the employees' EI is related to the quality of care for the aged care residents. Specifically, the care provided by emotionally intelligent employees is more likely to result in desired outcomes for the residents and consequently in an increased level of residents' satisfaction with the quality of patient care.

"Exploring the Association between Emotional Intelligence and Academic Performance and Stress Factors among Dental Students: A Scoping Review" a study done by Shah Saif Jahan et al.[19] found that

students with a higher EI may manage better with the stressful demands of their training, bolstering the case for including EI training in the curriculum of students of the health professions. Its inclusion in the dental curriculum may assist students in identifying their emotional characteristics and providing opportunities to teach them to a higher degree of competence in dealing with emotional intelligence, consequently increasing academic performance. Furthermore, this study bolsters the claim that emotional intelligence (EI) and the capacity to handle stress are essential traits of professional competence, and that EI should be used as a selection criterion for admission to dental education.

Anupsinh H. Chhasatia et al.[20] in their study on "Measuring Anger in Medical, Dental and Paramedical Post-graduate Students of Sumandeep Vidyapeeth, Vadodara, Gujarat, India: A Cross-Sectional Study" found that the overall anger was higher among post-graduate students. Post-graduate medical students had higher anger compared to paramedical post-graduate students. Female participants scored significantly lower on clinical anger compared to male participants. Post-graduates doing MD/MS were having significantly higher anger than post-graduates of MDS (p=0.002), MPT (0.000). Married participants scored lower on clinical anger compared to unmarried participants. Conclusion: Overall anger is high in medical post-graduate students which have negative implications on doctor-patient relationships and patient care can get compromised so it is necessary to find the ways through which we can lower the anger.

Sanjay Dixit et al[21] in their study " A Comparative Study To Find Out Emotional Quotient In Students Of M.G.M Medical College, Indore (MP), India", in 2014 concluded that post graduate students have poor Emotional Quotient as compared to MBBS Pre final & 1st prof students. This may be due to their busy and hectic schedule of work at hospitals & lack of awareness about EQ. The below observations are presented on the analysis of individual questions used in questionnaire. 53.3% of P.G. students, 43.3% of pre-final students and 58.3% 1st prof students adjust their behaviour according to whom they are interacting with. 43.3% P.G. Students and 48.3% of 1st prof students get nervous sometimes while 51.7% of pre-final students don't get nervous without any reason. 26.7% don't have compulsive habits while 35% of 1st prof students sometimes feel of having compulsive habits that they can't even stop. 48.3% don't get negative thoughts ever, while 41.7% of pre-final and 46.7% of 1st prof students disagree of getting negative thoughts. 48.3% of P.G. students sometimes seems to have unstoppable bothering and 31.7% of pre-final and 43.3% and 1st prof students don't have unstoppable bothering. 43.3% of P.G. students,41.7% of pre-final students and 36.7% of 1st prof students adjust their behavior with person whom they dislike also. 43.3% of P.G. students and 38.3% of 1st prof students sometimes need motivation to keep going while 40% of pre-final don't need motivation to keep themselves going.

45% of P.G. students and 40% of 1st prof students are not ashamed of how they look, While 60% of Pre-Final students are never ashamed of how they look. 28.3% of P.G. students and 30% of pre- final students never express their anger while 35% of 1st prof students disagree from expressing their anger. 40% of P.G. students, 58.3% of Prefinal students and 46.7% of 1st prof students agrees that they listen carefully to person.

Elizabeth J.Austin et al.[22] in their study "A preliminary study of emotional intelligence, empathy and exam performance in first year medical students" found that females scored significantly higher than males on EI. Exam performance in the autumn term on a course component (Health and Society) covering general issues in medicine was positively and significantly related to EI score but there was no association between EI and exam performance later in the year. High EI students reported more positive feelings about the communication skills exercise. Females scored higher than males on the Health and Society component in autumn, spring and summer exams. Structural equation modelling showed direct effects of gender and EI on autumn term exam performance, but no direct effects other than previous exam performance on spring and summer term performance. EI also partially mediated the effect of gender on autumn term exam performance. These findings provide limited evidence for a link between EI and academic performance for this student group. More extensive work on associations between EI, academic success and adjustment throughout medical training would clearly be of interest. A preliminary study of emotional intelligence, empathy and exam performance in first year medical students.

Rajkrishna Ravikumar at al.[23] in their study "A Study of Emotional Intelligence Among Postgraduate Medical Students in Delhi" in 2016 found that the emotional intelligence of postgraduate medical students in Delhi has been measured and has been found to increase with age and experience. It was also observed that emotional intelligence was negatively affected by an increase in the total workload of the resident doctors, having night duties, and emergency duties. However, it was not affected by factors like gender, religion, place of residence, choice of specialty, year of study, or past history of trauma

Aithal et al.[24] in their study "A survey-based study of emotional intelligence as it relates to gender and academic performance of medical students" in the year 2017, found a significant difference in EI by gender, with females' demonstrating higher EI scores. Their results were in line with the findings from previous research, also concluding that EI may vary related to gender with women scoring higher. According to literature, women tend to be more emotionally expressive than men; they understand

emotions better and have a greater ability with regard to certain interpersonal skills. Hence, it might be expected that EI will be higher in women than men. In addition, there is evidence that certain areas of the brain dedicated to processing emotions could be larger in women than in men; this could help explain differences in cerebral activity based on gender. Results also showed that the majority of students who obtained distinction and high distinction in the 1st year MBBS examination had high EI levels while students who obtained a pass grade had a low or moderate EI level. We found a positive relationship between EI and academic performance. These findings are also similar to previous work. We can postulate that EI plays an important role in predicting one's academic achievement.

Smrithi Shetty et al.[25] in their study "Assessment of Emotional Intelligence in First Year Medical Students: A Questionnaire Based Study" in the year 2013, concluded that good EI includes ability to understand and control emotions, to be empathetic, to be socially competent and so on and these qualities in turn improve an overall communication skill which adds on to the performance in the medical training. 1. Nearly 15 % of medical students had scores <15 in all domains of EI, implying urgent need to improve EI in these students. 2. Females had higher EI compared to males. 3. Good EI was found to be correlated with good sleep, good interpersonal relationship, recreational activities and exercise. Thus this study provides an insight into individuals EI and its relationship with professional, interpersonal and life style factors in medical students.

"Association Between Emotional Intelligence and Academic Performance Among Dental Hygiene Students" a study by Partido and Stafford et al.[26], in which they found that EI subsets of self-control, motivation, and self-confidence were found to be predictors of overall academic performance. The EI subsets of social competence, empathy, and motivation were found to be predictors of clinical performance. These results suggest that more attention to the development of emotional intelligence may lead to improved academic and clinical performance among undergraduate dental hygiene students.

Mitra et al.[27] in their study "Correlation among perceived stress, emotional intelligence, and burnout of resident doctors in a medical college of West Bengal: A mediation analysis" in the year 2018, found a significant positive correlation ($P < 0.001$) with perceived stress supported by a similar study by Swami et al. conducted among residents doctors. The current study has also revealed night duties and emergency duties to be correlated positively with burnout; however, the association was not significant. Swami et al. in their study found workload and night duties to have weak correlation whereas physical

fatigue factor to have significant correlation with workload. Gelfand et al. in their university-based study from the department of surgery revealed burnout to be present with high-emotional exhaustion (50%), high depersonalization (56%), and low personal accomplishment. Within 6 months of rescheduling of duty hours, only a minority of residents showed a low level of personal accomplishments (23%). Shirom et al. found that workload had no direct effect on burnout but mediated its effect through perceived stress. This may indicate toward other factors to be responsible. They found burnout to have negative correlation with TEI-well-being whereas positive correlation with TEI-self-control and sociability. Physical fatigue ($P < 0.001$) and cognitive weariness ($P = 0.04$) factors have significant positive correlations with TEI emotionality, and physical fatigue factor of burnout has negative correlation with TEI well-being; however, it was not statistically significant ($P > 0.05$). Weng HC found higher self-rated EI which was significantly associated with less burnout ($P < 0.001$) and higher job satisfaction ($P < 0.01$). Higher patient satisfaction was correlated with less burnout ($P < 0.04$) and less burnout was found to be associated with higher job satisfaction ($P < 0.001$). EI was found to be correlated with almost all subdimensions of burnout ($P < 0.01$–0.001). Higher EI was found to be correlated with less burnout and higher job satisfaction. A study in Indian perspective by Faye et al. found 70% of residents had poor EI and EI significantly was correlated with clinical anger. Pau AKH in a London-based study among dental undergraduates showed EI and its factors correlated positively with each other ($P < 0.01$) and inversely with total PSS score ($P < 0.01$). The current study, in mediation analysis, showed that TEI mediated the effect of perceived stress on burnout. A similar study by Swami et al., following the mediation analysis showed perceived stress to mediate the effect of TEI on Burnout..

Punya Sekhri et al.[28] in their study "Emerging Understanding of Emotional Intelligence of Teenagers" in the year 2017 found that empathy and self-actualization were highly developed in students of regular conventional school than those attending part-time unconventional coaching institute. The academic score had a significantly positive correlation with empathy, whereas a significantly negative correlation with interpersonal relations. Empathy, interpersonal relation, and impulsive control were significantly higher in females than males. Therefore by inculcating and working toward development of EI in the young generation, we can hope to achieve a more positive environment.

Subashini Sundararajan et al.[29] in their study "Emotional intelligence among medical students: a mixed methods study from Chennai, India" found that the students had emotional intelligence above the average, i.e., 40 being the maximum possible score, 20 is the average and the participants scored above 20 in each of the domains in the scale. Further it was found that students from government schools had

greater emotional intelligence than those from private schools. Girls had better response to emotional clinical vignettes than boys, however this was not statistically significant. The qualitative follow up study to explore the status of emotional intelligence revealed that the students perceived several positive and negative influences of emotions in the practice of medicine. They agreed that emotions are inevitable, and a doctor should know to balance and actively engage with them.

Eva M Doherty et al.[30] in their study "Emotional intelligence assessment in a graduate entry medical school curriculum" found that both male and female students rated their self-awareness competency at a lower level at T2 compared to T1 is in agreement with the evidence discussed above that empathy skills deteriorates over the course of medical training. Female students demonstrated superior emotional competencies on some of the self-report and ability EI scores. However females were also more likely to report deterioration in some of these emotional competencies over time. It may be that the medical education environment encourages females to adapt their interpersonal skills and emotional competencies to become more similar to their male counterparts. A number of self-report EI competencies were associated negatively with performance on some of the academic modules and this warrants further investigation. The finding that those students who rated themselves highly on certain emotional competencies were also more likely to obtain low scores on assessments of their clinical and communication skills may be an indication of their lack of insight into their true abilities or may be to do with the validity of the assessments themselves. An inverse relationship between certain self-report EI competencies and performance on clinical OSCEs was identified again at T2 and this supports the possible association between lack of insight and poor clinical performance. In contrast, strong to medium positive correlations between the EQ-i subscale Impulse Control and four module scores were demonstrated at T1 such that a perceived high ability to manage frustration was associated with high scores on these knowledge based assessments. However at T2, an inverse association between certain selfreport EI competencies and performance on one of the knowledge based modules was found which indicates that the relationship between self-reported EI and actual academic performance is not straightforward and should be investigated further.

MATERIAL AND METHODS

MATERIALS & METHODS:

Study Design: A cross-sectional study will be conducted in a tertiary care medical institute of Santosh medical college & hospitals.

Place of study: Santosh medical college & hospitals, Ghaziabad.

Study group: Doctors(Registered) working in Santosh medical College & Hospital, Ghaziabad.

Study Size: Total Enumeration Sampling (156)

Study Period: 2020-2022

Inclusion criteria: Registered doctors working in Santosh Medical college & hospitals. Those who have given written informed consent.

Exclusion criteria: Those who did not give informed consent.

Methodology

Ethical clearance will be obtained from the Institute's Ethical Committee. Permission will be obtained from the Institution. All the participants will be provided with written and informed consent proforma to be signed by them. Those participants who will be giving their consent will be included in the study. Participants will be given instructions for filling the semi-structured proforma and other psychiatric rating scales.

Following psychiatric rating scales were used for the collection of data: -

- Self-constructed semi-structured proforma- It includes details about sociodemographic profile.
- Emotional Quotient Self-Assessment Checklist
- Multi-Dimensional Emotional Empathy Scale
- Clinical Anger Scale

Semi-Structured Proforma:A semi-structured proforma will be made to collect socio-demographic details like name, age, gender, year of education, residential background, family and personal history of psychiatric illnesses, etc.

Emotional Quotient Self-Assessment Checklist[31]:- Devised by Sterrett, it consists of 30 statements.

Multi-Dimensional Emotional Empathy Scale[32]:-

Devised by Caruso and Mayer. It has 30 statements covering the following factor scales:- Suffering, Positive Sharing, Responsive Crying, Emotional Attention, Feel for Others & Emotional Contagion.

This is a 5-point Likert rating ranging from 1 to 5 with 6 reverse-scored items (scoring from 5–1). General Empathy scale, consisting of 26 items of the six factor scales, has a mean of 3.53 (SD=0.60) and an alpha reliability of 0.86.

Clinical Anger Scale (CAS)[33]:-

devised by William E. Snell Jr has 21 items. Each cluster of statements is scored on a 4-point Likert scale, with A=0, B=1, C=2 and D=3. The subject's responses on the CAS are summed so that higher scores correspond to greater clinical anger.

Scoring Instructions for the Clinical Anger Scale (CAS):

Each cluster of statements was scored on a 4-point Likert scale, with A = 0, B = 1, C = 2, and D = 3.

Subjects' responses on the CAS were summed so that higher scores corresponded to greater clinical anger (21 items; range 0 - 63).

CAS scores is accomplished through the following interpretive ranges: 0-13 - minimal clinical anger; 14-19 - mild clinical anger; 20-28 - moderate clinical anger; and 29-63 - severe clinical anger.

OBSERVATIONS AND RESULTS

OBSERVATION AND RESULTS:

Table 1: Distribution of study population according to

Age	Frequency	Percent
21-25 years	21	13.5%
26-30 years	77	49.4%
31-35 years	30	19.2%

36-40 years	11	7.1%
Above 40 years	17	10.9%

Majority of the subjects belonged to 26-30 years (49.4%) followed by 31-35 years (19.2%), 21-25 years (13.5%), Above 40 years (10.9%) and 36-40 years (7.1%).

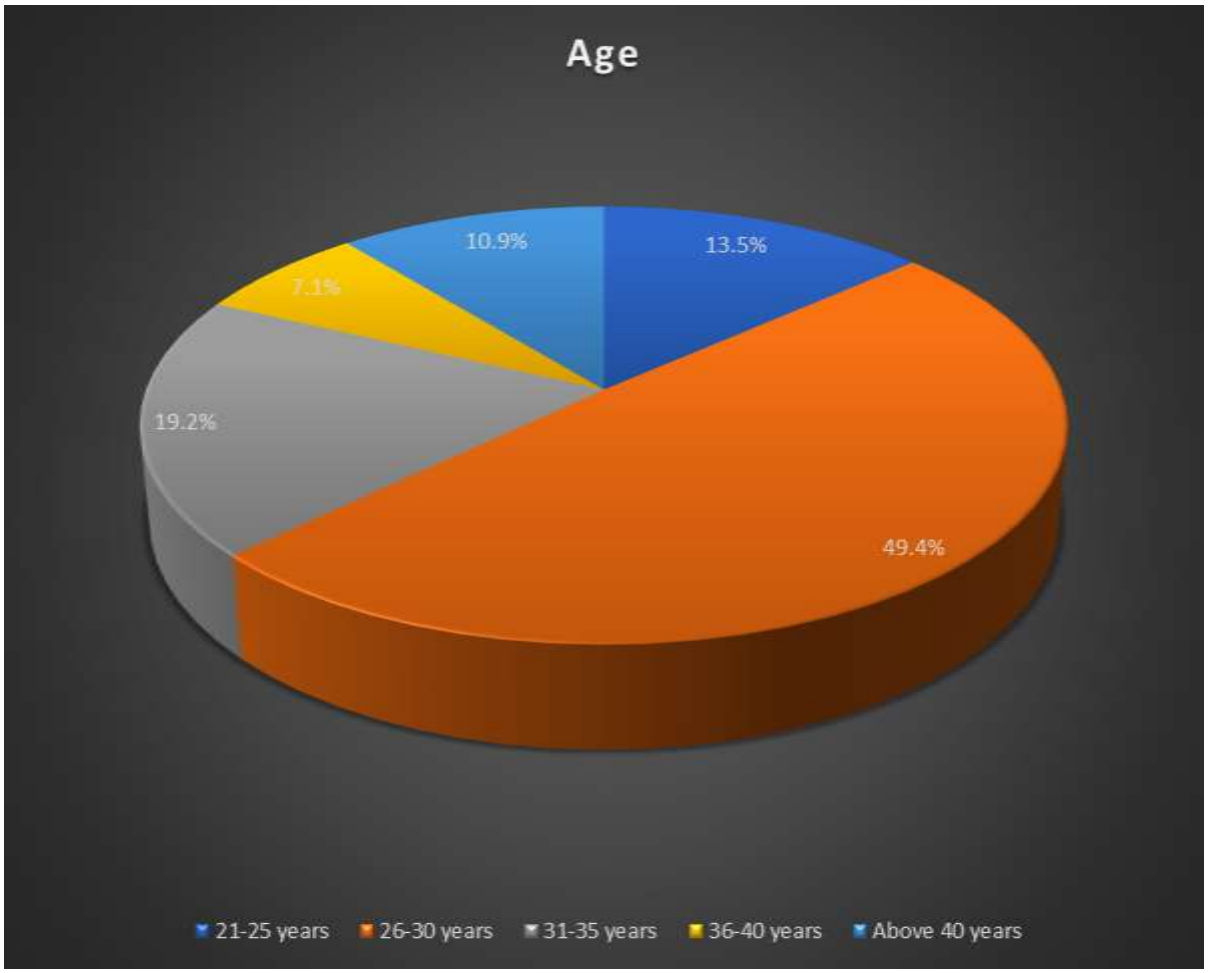


Table 2: Distribution of study population according to

Gender	Frequency	Percent
Male	96	61.5%
Female	60	38.5%
Total	156	100.0%

There were 61.5% males and 38.5% females.

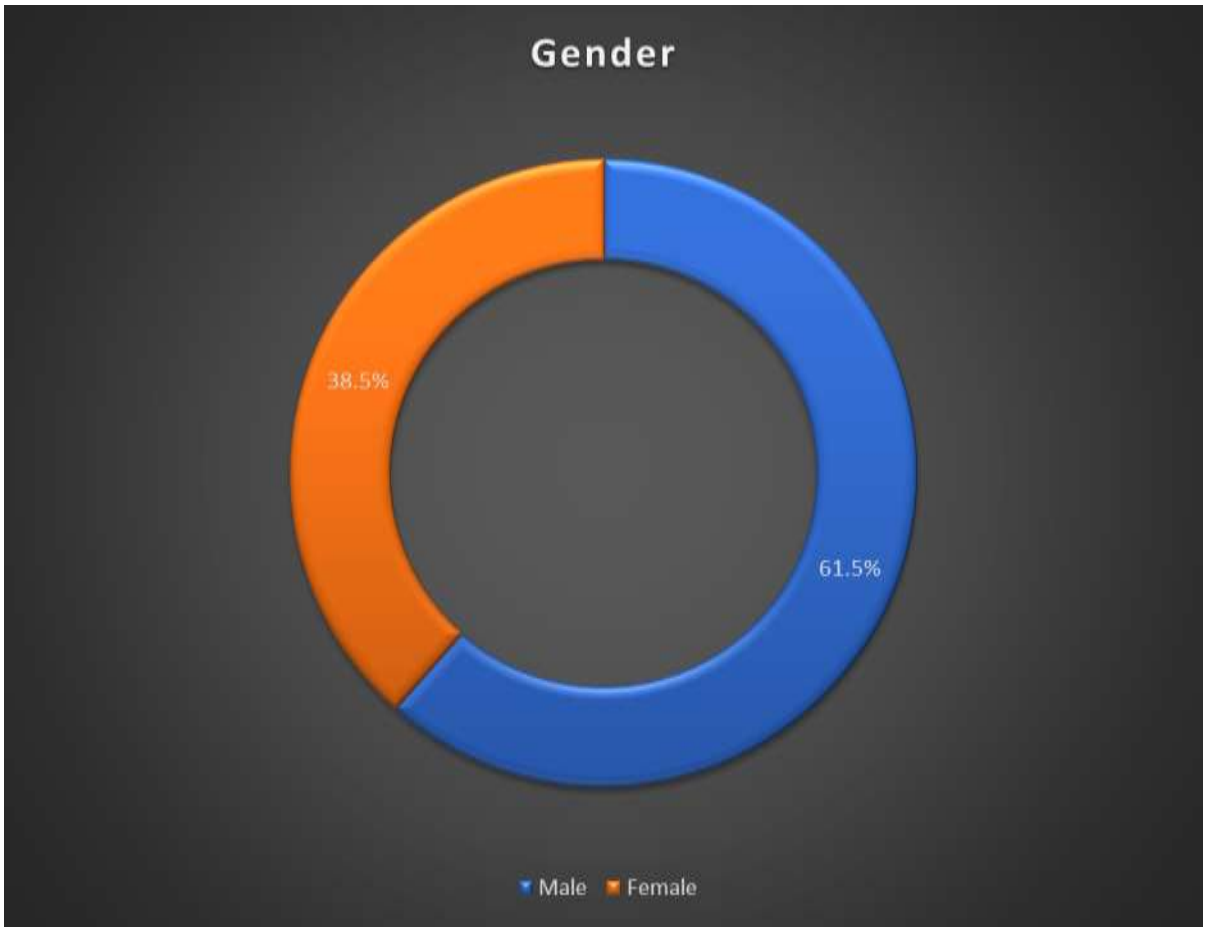


Table 3: Distribution of study population according to

Marital Status	Frequency	Percent
Married	65	41.7%
Other	5	3.2%
Unmarried	86	55.1%
Total	156	100.0%

As per marital status, there were 41.7% married, 3.2% others and 55.1% unmarried.

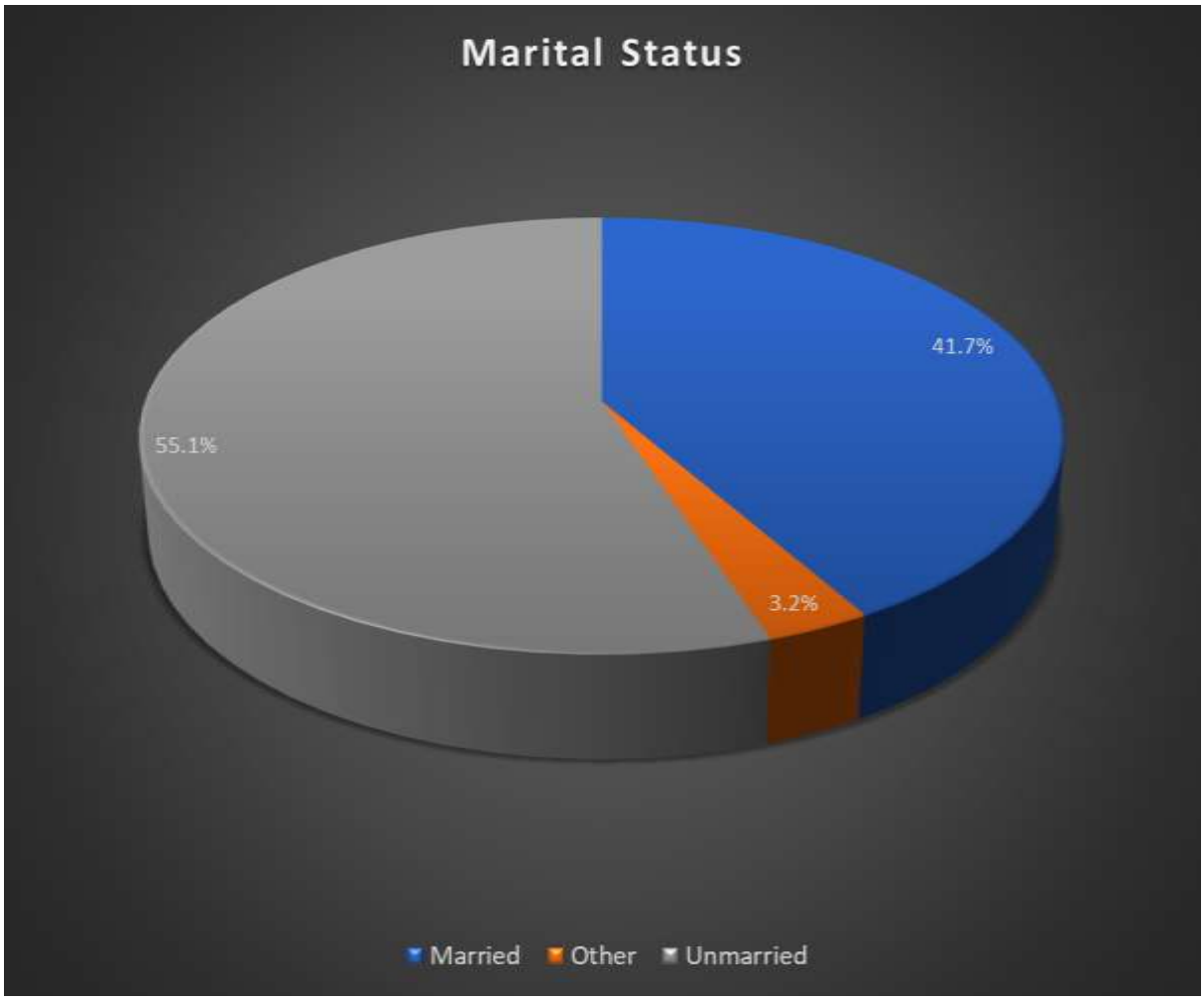


Table 4: Distribution of study population according to

Religion	Frequency	Percent
Hindu	136	87.2%
Muslim	10	6.4%
Others	6	3.8%
Sikh	4	2.6%

Total	156	100.0%

As per religion, most (87.2%) of them were Hindus, followed by Muslims (6.4%), Others (3.8%) and Sikh (2.6%).

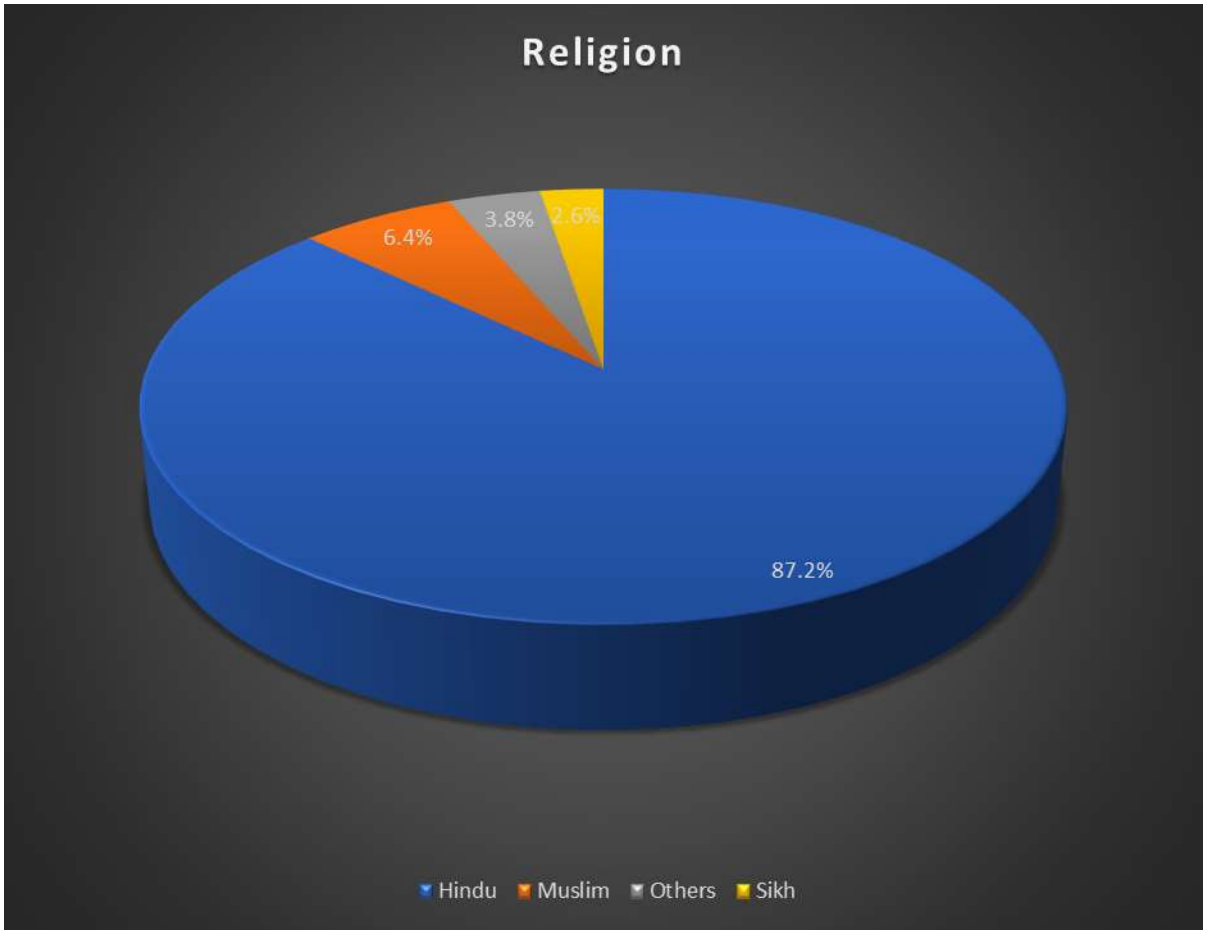


Table 5: Distribution of study population according to

Any past psychiatric history	Frequency	Percent
No	135	86.5%
Yes	21	13.5%
Total	156	100.0%

Any past psychiatric history was reported among 13.5% subjects.

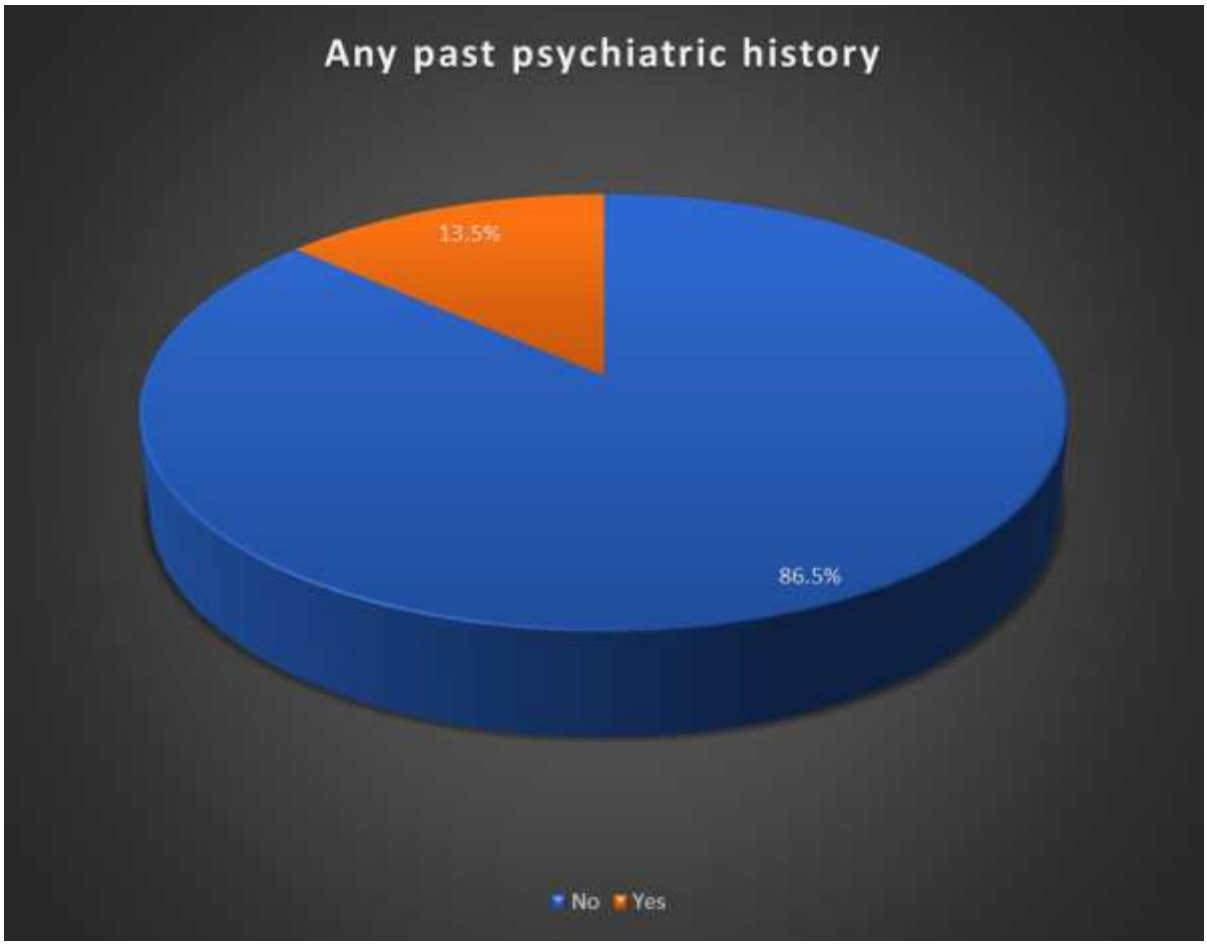


Table 6: Distribution of study population according to

Designation	Frequency	Percent
Junior resident	77	49.4%
Senior resident	49	31.4%
Consultant	30	19.2%

There were 49.4% Junior residents, 31.4% Senior residents and 19.2% consultants.

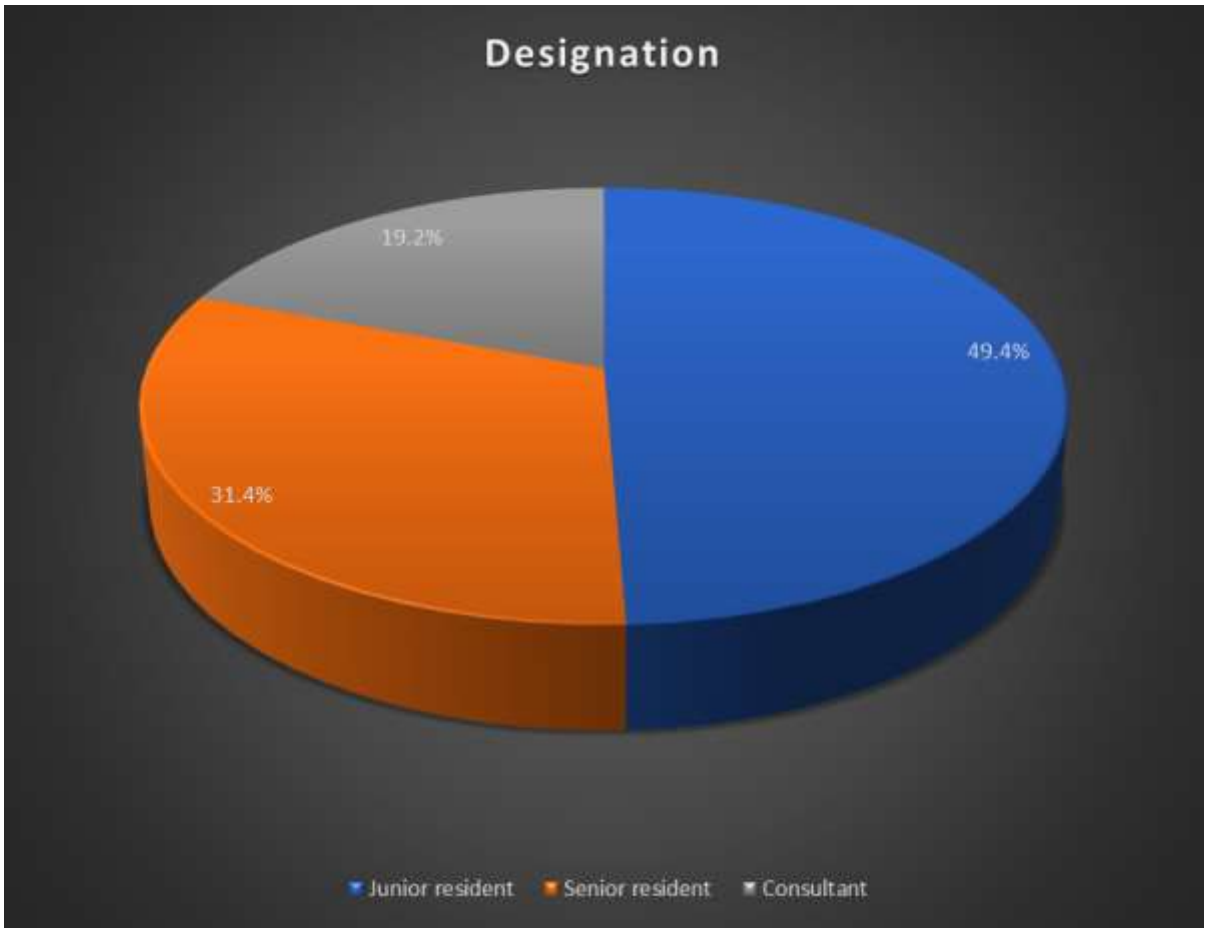


Table 7: Distribution of study population according to

		Mean	Std. Deviation	F-value	p-value	
Empathy	21-25 years	86.58	10.27	5.248	0.001*	
	26-30 years	90.79	11.89			
	31-35 years	94.90	11.59			

	36-40 years	98.73	17.65			
	Above 40 years	103.95	11.22			
Self awareness	21-25 years	10.89	1.85	6.647	0.001*	
	26-30 years	11.65	2.60			
	31-35 years	12.93	2.61			
	36-40 years	13.55	3.01			
	Above 40 years	14.84	2.34			
Self assessment	21-25 years	10.95	2.01	6.301	0.001*	
	26-30 years	11.90	2.81			
	31-35 years	12.60	3.15			
	36-40 years	13.36	3.17			
	Above 40 years	14.89	3.31			
Self confidence	21-25 years	8.79	1.44	5.792	0.001*	
	26-30 years	9.38	2.20			
	31-35 years	10.47	2.46			
	36-40 years	11.45	2.54			
	Above 40 years	12.95	2.25			
Clinical Anger Scale	21-25 years	14.79	10.37	5.063	0.001*	
	26-30 years	18.60	13.12			
	31-35 years	23.83	10.44			
	36-40 years	27.09	14.94			
	Above 40 years	32.32	11.06			

The mean Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale increased significantly with age.

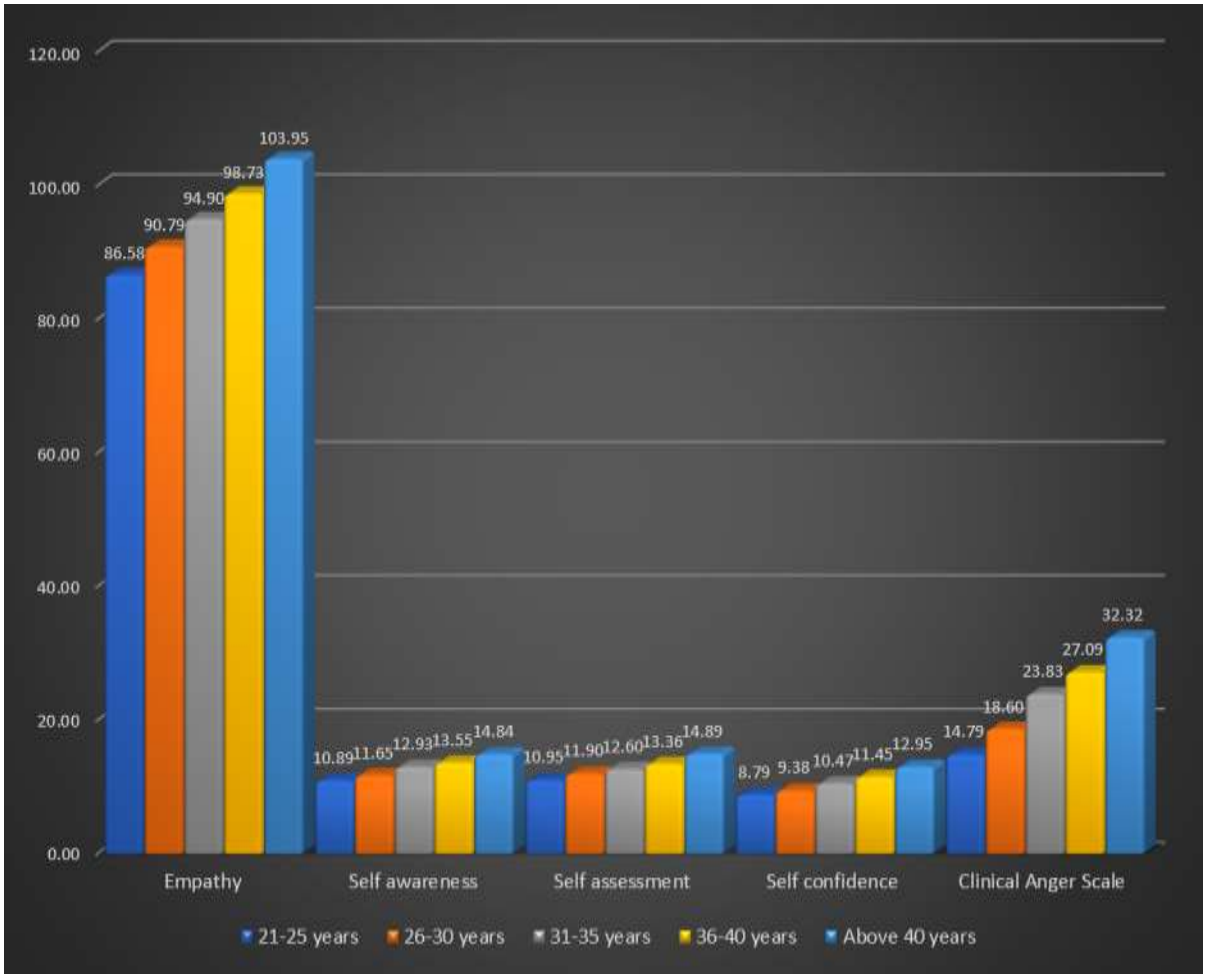


Table 8: Distribution of study population according to

	Male		Female		
	Mean	Std. Deviation	Mean	Std. Deviation	p-value
Empathy	97.73	12.51	100.68	12.88	0.158
Self-awareness	13.48	2.74	14.15	2.61	0.132
Self-assessment	13.45	3.19	13.83	2.89	0.448

Self-confidence	10.00	2.33	10.17	2.38	0.667
Clinical Anger Scale	19.08	13.50	15.47	11.54	0.088

There was no significant difference in mean Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale between males and females.

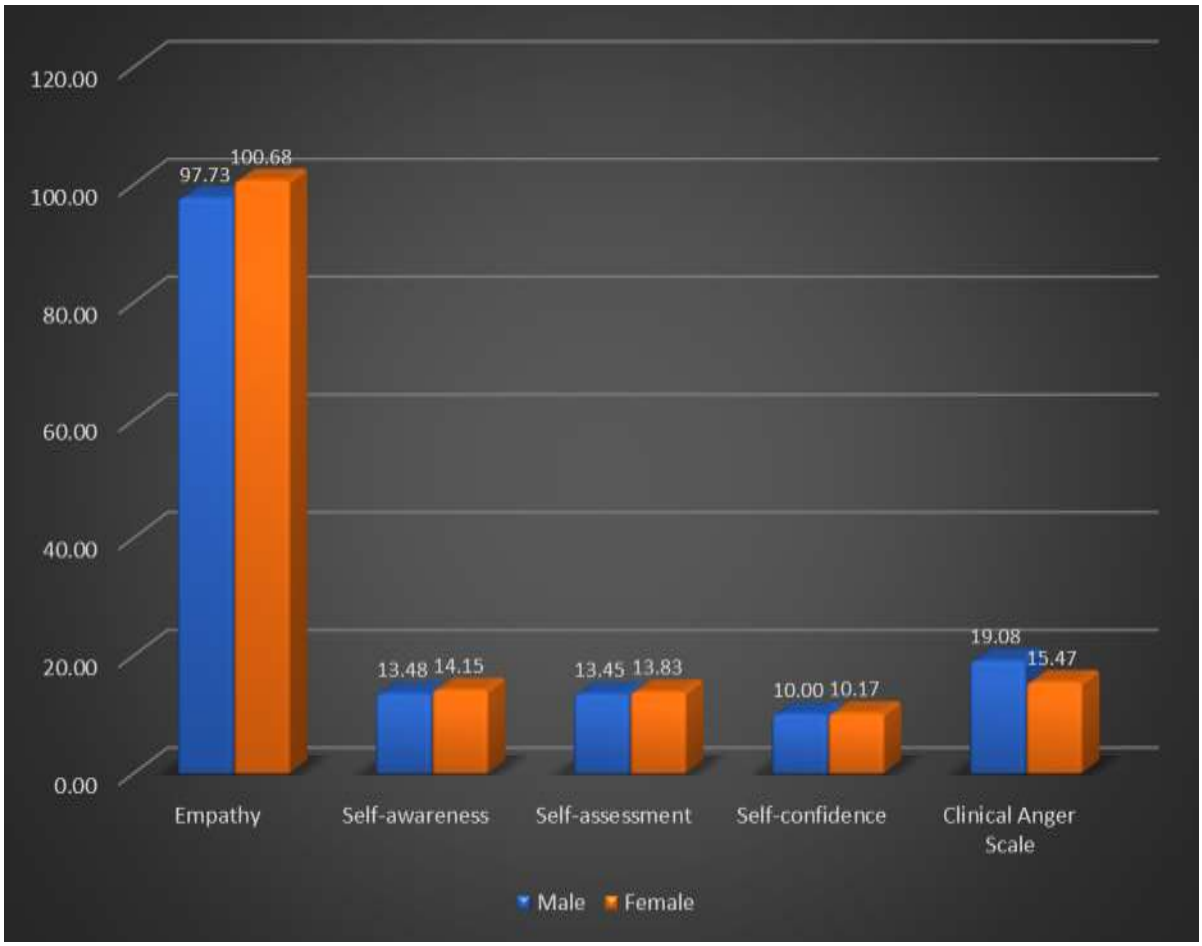


Table 9: Distribution of study population according to

	No past psychiatric history		Past psychiatric history		
	Mean	Std. Deviation	Mean	Std. Deviation	p-value
Empathy	101.00	11.14	85.14	13.74	0.001*

Self-awareness	14.10	2.47	11.43	3.03	0.001*
Self-assessment	13.97	3.02	11.19	2.32	0.001*
Self-confidence	10.41	2.13	7.86	2.48	0.001*
Clinical Anger Scale	15.98	12.61	28.71	8.29	0.001*

The mean Empathy, Self-awareness, Self-assessment and Self-confidence was significantly more among subjects with No past psychiatric history. The mean Clinical Anger Scale was significantly more among subjects with past psychiatric history.

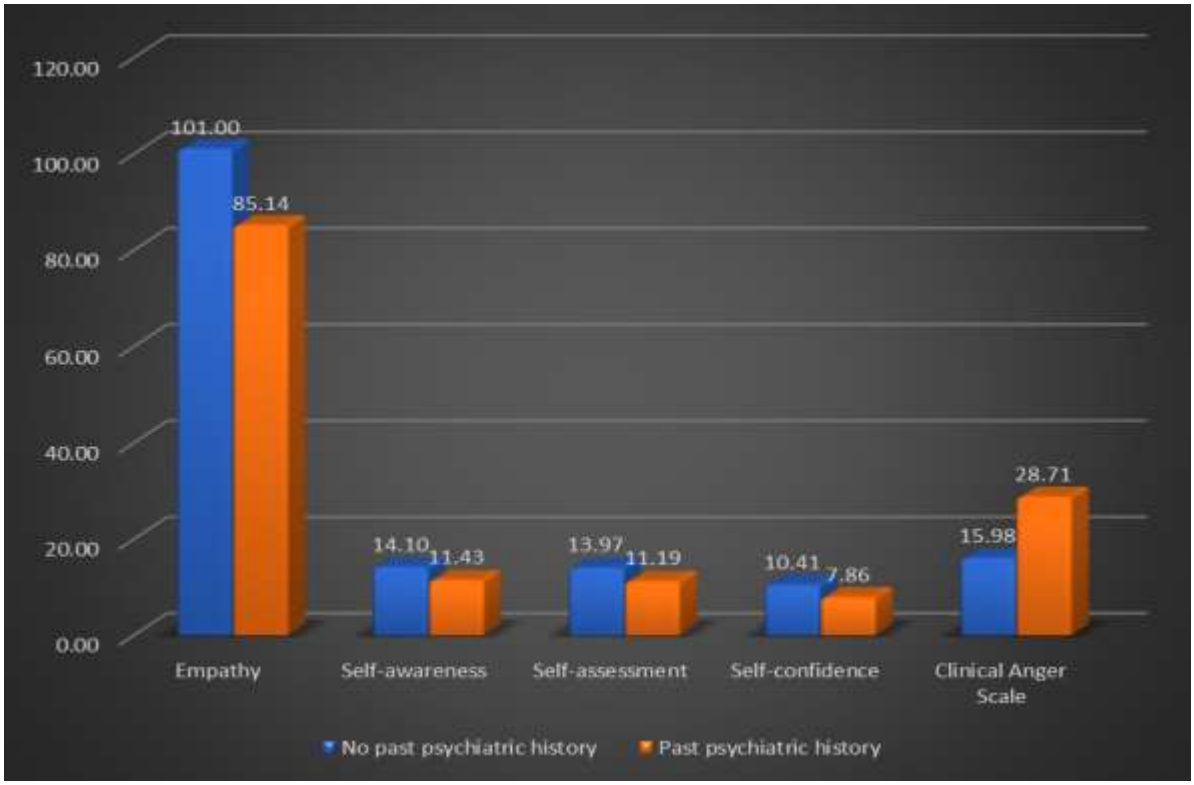
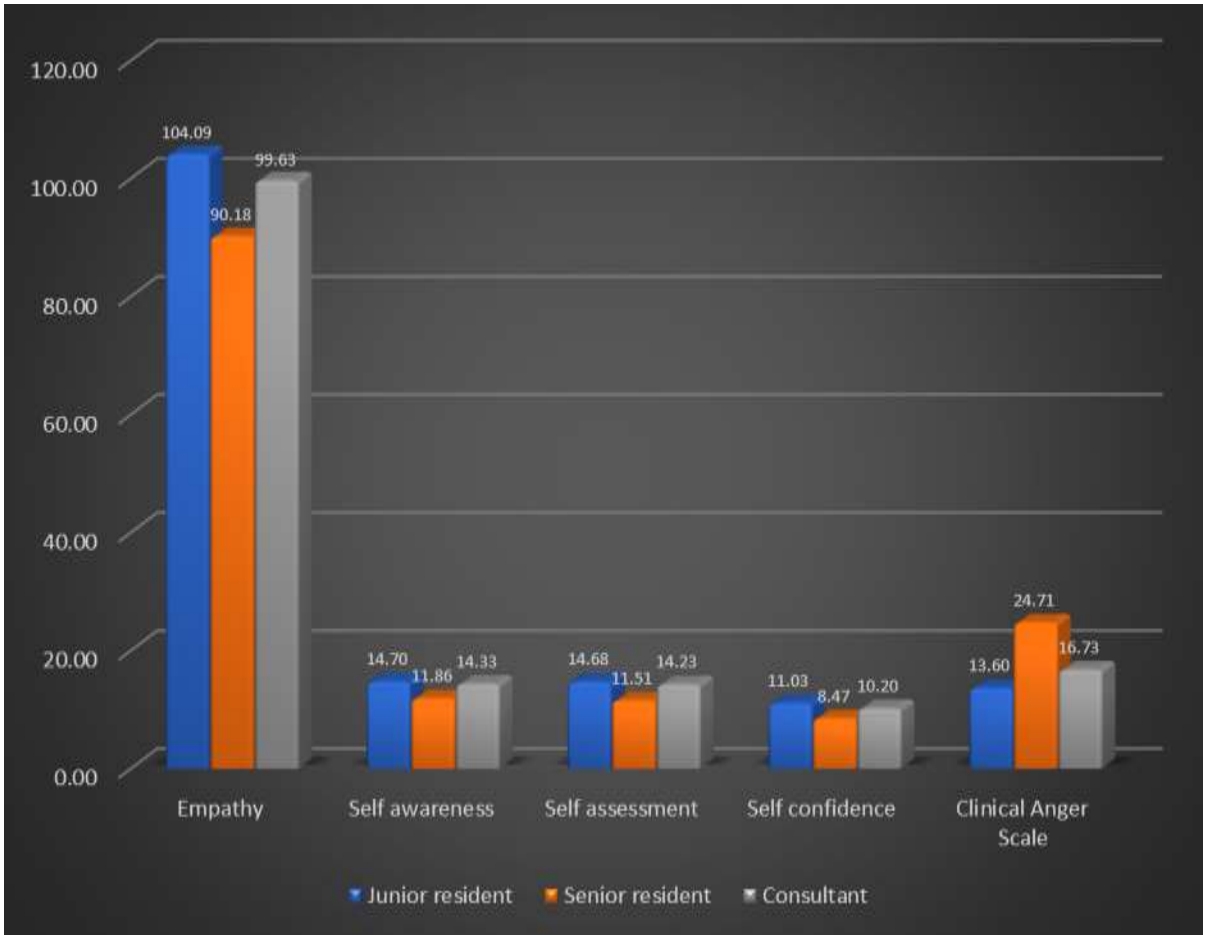


Table 10: Distribution of study population according to

		Mean	Std. Deviation	F-value	p-value	Post-hoc comparisons
Empathy	Junior resident	104.09	7.85	23.223	0.001*	
	Senior resident	90.18	13.70			
	Consultant	99.63	13.72			

Self awareness	Junior resident	14.70	1.96	22.286	0.001*	
	Senior resident	11.86	2.84			
	Consultant	14.33	2.60			
Self assessment	Junior resident	14.68	2.01	20.913	0.001*	
	Senior resident	11.51	2.99			
	Consultant	14.23	3.78			
Self confidence	Junior resident	11.03	1.66	23.011	0.001*	
	Senior resident	8.47	2.21			
	Consultant	10.20	2.68			
Clinical Anger Scale	Junior resident	13.60	12.25	13.040	0.001*	
	Senior resident	24.71	10.89			
	Consultant	16.73	12.87			

The mean Empathy, Self-awareness, Self-assessment and Self-confidence was significantly more among Junior resident. The mean Clinical Anger Scale was significantly more among Senior resident.


120.00
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14.23
11.03
8.47
10.20
13.60
24.71
16.73
Empathy
Self awareness
Self assessment
Self confidence
Clinical Anger Scale
Junior resident
Senior resident
Consultant

DISCUSSION

DISCUSSION:

Communication that is characterized by empathy is vital in the doctor-patient interaction. However, recent research[34-36] found that the level of empathy students exhibited throughout their time at academic medical schools decreased with time. Recent studies have been conducted on EI and empathy in medical students and physicians to determine what factors, such as personality, gender, and experience, influence on their empathic perceptions[37-40]. These studies aimed to find out what factors influence on their empathic perceptions. Unfortunately, the majority of modern medical education emphasizes hard skills training. The need for hands-on soft skills training is acute, and resident medical doctors are expected to acquire the necessary abilities on their own.

Age

In our study, majority of the subjects belonged to 26-30 years (49.4%) followed by 31-35 years (19.2%), 21-25 years (13.5%), Above 40 years (10.9%) and 36-40 years (7.1%). Faye et al.[41] reported that a majority, that is, 74.7% of the subjects belonged to the 23-27 years age group. Ukey et al.[43] found that the mean age of the study participants was 26.7±3.11 years. The age was in the range of 24 to 38 years. Ravikumar et al.[43] stated that the average age of the research participants was 26 years, with 82% falling in the 25–28 age range.

Gender

In present study, there were 61.5% males and 38.5% females. Faye et al.[41] reported that 68.7% were males, while 31.3% were females. Ukey et al.[42] found that post graduate male students was 56% and female students were 44%. Ravikumar et al.[43] stated that almost 70% (139) of the postgraduate students were male.

Marital status

As per marital status, there were 41.7% married, 3.2% others and 55.1% unmarried. Faye et al.[41] reported that 38.7% of the residents were married of which 60% had children. Ravikumar et al.[40] stated that most of the participants were single/unmarried (86.5%) while the rest were married (13.5%).

Past Psychiatric History

Any past psychiatric history was reported among 13.5% subjects. Ravikumar et al.[43] reported that Out of the total number of participants, 35 (17.5%) reported having a source of significant stress in their life. Stress was mostly reported to be due to work or academics

Specialities

There were 49.4% Junior residents, 31.4% Senior residents and 19.2% consultants. Faye et al.[41] reported that 62.7% of subjects were from the medical specialties, whereas 37.3% were from the surgical specialties. Ravikumar et al.[43] stated that the participants in the research were enrolled in postgraduate programs in surgery and related fields (46%) and medicine and related fields (54%).

Association of Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale with Age

The mean Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale increased significantly with age. Faye et al.[41] observed that the self-control (P=0.04) and overall empathy (P=0.03) scores of individuals (27–31 years old) were considerably higher than those of the younger subjects (23–27 years). The latter, however, valued positive sharing more (P=0.002) with others. There was no connection between age and clinical rage. In contrast to our findings, Kassam et al.[44] stated that there was no significant correlation between age and any of the subscales of EI.

Ravikumar et al.[43] found that students show a correlation of 0.187 and a significant improvement in their emotional intelligence as they age ($p = 0.008$). This conforms to the results obtained by McKinley et al.[45], Weng et al.[46] and Zeidner et al.[47]. As a person gets older, they have more experiences in life, and as they grow, they become more sensitive to their own emotions as well as the feelings of others around them.

A greater age was shown to have a clear correlation with a higher EI. The development of emotional intelligence (EI) is significantly influenced by the individual's life experiences. As

people become older, they generally have a greater sensitivity to the emotions and experiences of those around them[48-50].

Association of Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale with Gender

There was no significant difference in mean Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale between males and females. Faye et al.[41] observed that When compared to females, men had considerably higher mean scores for each of the EI subscales, with empathy being about equal in both sexes. Male inhabitants were shown to be more self-assured and more sympathetic to the suffering of others (P=0.004) than female residents. In contrast to females, who had higher mean scores on the empathy scale for positive sharing, emotional attention, feel for others, and emotional contagion, men had higher mean scores for suffering and responsive sobbing. Gender did not seem to affect anger.

Sterrett et al[51]. reported findings that were comparable, despite the fact that Austin et al.[52] and Singh et al.[53] discovered the opposite. One of the qualities that may lead to a better understanding and, as a result, to a stronger empathic relationship is the fact that women are naturally more open to emotional cues than men are.

A research that used meta-analysis found that women had greater levels of anxiety and lower levels of agreeability[54]. When compared to men, females are more likely to show their feelings and are more adept at communicating with other people[55]. This is particularly true for Japanese women, who have been shown to be more sensitive to interpersonal interactions inside a cooperative group and to compare themselves to other members of the group[56]. As a result, female Japanese medical students had better levels of empathy as well as greater agreeability than their male counterparts.

According to our findings, there were no discernible gender disparities in EI. In other studies of medical students, researchers have come to contradictory conclusions about the relationship between EI and gender[36,37,52,57]. In this particular research, a regression analysis was performed, and although gender and personality were both controlled for, it was shown that gender did not have an effect on EI or empathy; rather, personality was the most

significant element. This finding suggests that students' personalities have an effect on their ability to empathize with others.

Ukey et al.[42] found that The gender comparison of emotional intelligence (EI) showed that emotional awareness and management were better in male postgraduate students than in female postgraduate students, and emotional management was statistically considerably more prevalent in males. The other two domains' ratings were almost comparable in both cases. This result contrasts with a research conducted in Bangalore by Subramanian A et al.[58] who found that when EI scores were compared by gender, there were several subscales (self-management) where there were substantial gender differences, with a tendency for males to do somewhat better.

Males were shown to have higher EI scores in studies conducted in India, Pakistan, Iran, Egypt, and Trinidad, while females were found to have higher EI scores in research conducted in the UK, USA, Japan, Malaysia, Australia, New Zealand, Greece, and Romania. Even a few surveys conducted in Pakistan and India agreed that women dominated. Other healthcare research, however, did not detect any significant differences in EI across genders[59].

This may be due to the diverse cultural norms that exist throughout societies, with female dentists in affluent countries being more able to express their feelings and interact freely with their patients. Gender differences in EI ratings have been explained by a number of different theories. Researchers believe that the main contributing variables may be biological variations and discrepancies in early childhood socialization within same-sex playgroups, particularly adherence to culturally prescribed gender role expectations[59].

Association of Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale with past psychiatric history

The mean Empathy, Self-awareness, Self-assessment and Self-confidence was significantly more among subjects with No past psychiatric history. The mean Clinical Anger Scale was significantly more among subjects with past psychiatric history.

Ravikumar et al.[43] found that the emotional intelligence of postgraduate students who reported having a significant source of stress in their lives (122.2 12.9) was lower than the emotional intelligence of residents who did not report having such a source of stress in their

lives (124.8 12.8); however, this difference did not prove to be statistically significant. People who have been through traumatic experiences, whether they be physical or mental, would have greater expertise in coping with and controlling unpleasant emotions because of their experiences. Because of this, it would show up as a reflection in their overall emotional intelligence.

Faye et al.[41] revealed their findings, which claim that inhabitants who had some difficulty at home had a stronger self-awareness and sensitivity to pain than those who did not have any problems at home. Because of this, ultimately their bedside manner and their ability to handle patients would suffer. In the course of our research, we investigated the possibility of a prior history of severe mental or physical abuse occurring within the previous year. There was no significant differences between the residents who had experienced trauma and those who had not in our observations of the two groups of residents.

Association of Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale with Designation

The mean Empathy, Self-awareness, Self-assessment and Self-confidence was significantly more among Junior resident than senior residents and Consultants. The mean Clinical Anger Scale was significantly more among Senior resident. Faye et al.[41] reported that a higher EI was correlated with both more satisfaction with one's work and greater autonomy over that profession. As can be observed in this case, an intrinsic discontent with the work profile would undoubtedly be a disincentive in the provision of patient care.

According to the findings of the research by Azimi et al.[60], participants who were married had excellent EI. The building blocks of a happy marriage include adaptability, trustworthy communication, mutual understanding, and comprehension of one another. Having to deal with the multitude of feelings that arise as a result of sharing one's life with a significant other and, at times, members of one's extended family, enables a person to keep their emotions under control and settle disagreements peacefully. This mentality very certainly gets carried over into other facets of the persons' lives, including the care that is provided to patients.

However, it's not uncommon for those who work in the health care industry to experience burnout. Therefore, in order to keep going, one has to motivate themselves. Postgraduates who participated in a communication skills session on at least one occasion during their

residency reported better levels of motivation. Because of this, it is reasonable to conclude that emotional intelligence and the ability to communicate effectively go hand in hand. A high emotional intelligence (EI) involves the capacity to understand and manage one's emotions, to empathize with others, to be socially competent, and so on; in turn, these abilities increase one's ability to communicate effectively[41].

Scholars have made many efforts to instruct medical students in training in EI[61]. Medical students have been taught to recognize and comprehend their own emotions via the use of cognitive reflection exercises, realistic role-play situations, sociodrama techniques, and conflict resolution procedures[62]. Additionally, it has been suggested that the beginning of an emotional intelligence training program should be a methodical reflection of a student's feelings in a person and a face-to-face conversation with a mentor regarding emotionally hard clinical scenarios[63].

SUMMARY

SUMMARY AND CONCLUSIONS:

The study findings can be summarized as follows:

- Majority of the subjects belonged to 26-30 years (49.4%) followed by 31-35 years (19.2%), 21-25 years (13.5%), Above 40 years (10.9%) and 36-40 years (7.1%).
- There were 61.5% males and 38.5% females.
- As per marital status, there were 41.7% married, 3.2% others and 55.1% unmarried.
- As per religion, most (87.2%) of them were Hindus, followed by Muslims (6.4%), Others (3.8%) and Sikh (2.6%).
- Any past psychiatric history was reported among 13.5% subjects.
- There were 49.4% Junior residents, 31.4% Senior residents and 19.2% consultants.
- There was no significant difference in mean Empathy, Self-awareness, Self-assessment, Self-confidence and Clinical Anger Scale between males and females.
- The mean Empathy, Self-awareness, Self-assessment and Self-confidence was significantly more among subjects with No past psychiatric history. The mean Clinical Anger Scale was significantly more among subjects with past psychiatric history.
- The mean Empathy, Self-awareness, Self-assessment and Self-confidence was significantly more among Junior resident. The mean Clinical Anger Scale was significantly more among Senior resident.

Following were the conclusions from this study:

Communities of learning may help students develop their emotional intelligence abilities, highlighting the need of community-focused medical education. It also shown that, despite men and women having identical levels of emotional intelligence (EI), women are

better at reacting properly to emotionally charged clinical vignettes, suggesting that they are better able to use EI to provide clinical care.

Effective time management, sufficient sleep, and positive relationships with subordinates and superiors are crucial factors in determining emotional intelligence among medical postgraduates. EI is developed via experiences with emotional difficulties, learning in workshops on communication skills, and improved support systems in marriage.

A postgraduate level's development of EI, empathy, and clinical rage recognition may serve as a model for early development of the same. The research also revealed that appropriate cognitive reflection activities may aid students in comprehending the significance of emotions in the practice of medicine and can serve as a suitable foundation for developing emotional intelligence skills.

FURTHER RECOMMENDATIONS

FURTHER RECOMMENDATIONS

1. This was a cross-sectional study, and as we had few faults in our study, we recommend longitudinal studies be conducted.

2. This study was conducted on doctors of our college, so the study sample was comparatively less. We recommend conducting a study with a larger study sample.

3. To establish a cause-and-effect relationship regressional analysis is to be done.

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BIBLIOGRAPHY

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ANNEXURE-A

DEPARTMENT OF PSYCHIATRY

SANTOSH MEDICAL COLLEGE & HOSPITAL

GHAZIABAD, U.P

SUBJECT INFORMATION SHEET

You are being requested to take part in a study entitled "Attitude of Medical students towards Suicide & its prevention".

VOLUNTARY PARTICIPATION

Your participation in this study is entirely voluntary and you are free to withdraw from this study as and when you feel so.

RISK (IF ANY)

This is a safe study. There is no risk involved per se.

CONSENT FORM

I _____ have been explained by Dr. Ram Mehar Sheoran about the nature of study. I volunteer to take part in the study "Emotional Intelligence, Empathy and Clinical Anger in doctors working in a tertiary care hospital" and have also explained to me the purpose of the study to my satisfaction. I hereby give my consent to be enrolled in the study.

Signature of participant:

Date:

ANNEXURE-A

Proforma for socio-demographic data

- Age:
- Sex: male/ female
- Department:
- Marital status:
- Religion:
- Any Past Psychiatric history:
- Designation:

ANNEXURE-B

EMOTIONAL INTELLIGENCE QUESTIONNAIRE

EMPATHY SCALE				
1.I feel like crying when watching a sad movie				
2.Certain pieces of music can really move me.				
3.Seeing a hurt animal by the side of the road is very upsetting.				
4.I don't give others' feelings much thought.				
5.It makes me happy when I see people being nice to each other.				
6.The suffering of others deeply disturbs me.				

7.I always try to tune in to the feelings of those around me.				
8.I get very upset when I see a young child who is being treated meanly				
9.Too much is made of the suffering of pets or animals				
10.If someone is upset I get upset, too.				
11.When I'm with other people who are laughing I join in.				
12.It makes me mad to see someone treated unjustly.				
13.I rarely take notice when people treat each other warmly.				
14.I feel happy when I				

see people laughing and enjoying themselves.				
15. It's easy for me to get carried away by other people's emotion				
16.My feelings are my own and don't reflect how others feel.				
17.If a crowd gets excited about something so do I.				
18.I feel good when I help someone out or do something nice for someone.				
19.I feel deeply for others.				
20.I don't cry easily.				
21.I feel other people's pain.				

22.Seeing other people smile makes me smile				
23.Being around happy people makes me feel happy, too.				
24.TV or news stories about injured or sick children greatly upset me.				
25.I cry at sad parts of the books I read.				
26.Being around people who are depressed brings my mood down.				
27.I find it annoying when people cry in public.				
28.It hurts to see another person in pain.				
29.I get a warm feeling for someone if I see				

them helping another person.				
30.I feel other people's joy.				

SELF-AWARENESS SCALE-Emotional Awareness Scale:				
1. I always know which emotions I am feeling and why				
2. I realize the links between my feelings and what I think, do, and say				
3. I recognize how my feelings affect my performance				
4. I have a guiding awareness of my values and goals				

Accurate Self-Assessment: Knowing one's strengths and limits.				
1. I am aware of my strengths and weaknesses				
2. I am reflective and try to learn from experience				
3. I am open to candid feedback, new perspectives, continuous				
4. I am able to show a sense of humour and perspective about myself				

Self-Confidence: Sureness about one's self-worth and capabilities.				
1. I present myself with self-assurance; I have				

"presence"				
2. I can voice views that are unpopular and go out on a limb for what is right				
3 .I am decisive, and able to make sound decisions despite uncertainties and pressures				

ANNEXURE-C

Clinical Anger Scale

FEELINGS INVENTORY INSTRUCTIONS: The group of items below inquire about the types

of feelings you have. Each of the 21 groups of items has four options.

For example, ...A.... A. I feel fine.

B. I don't feel all that well.

C. I feel somewhat miserable.

D. I feel completely miserable.

For each cluster of items, read and identify the statement that best reflects how you feel.

For example, you might choose A in the above example. If so, then circle the letter (A) next

to the item number associated with that group of statements.

Answer the questions even if you're not sure. Make sure you select only one statement

from each of the 21 clusters of statements.

Question	A	B	C	D
1	I do not feel angry.	I feel angry.	I am angry most of the time now.	I am so angry and hostile all the time that I can't stand it.
2	I am not particularly angry about my	When I think about my future, I feel angry.	I feel angry about what I have to look	I feel intensely angry about my future, since it

	future.		forward to.	cannot be improved.
3	It makes me angry that I feel like such a failure.	It makes me angry that I have failed more than the average person.	As I look back on my life, I feel angry about my failures.	It makes me angry to feel like a complete failure as a person.
4	I am not all that angry about things.	I am becoming more hostile about things than I used to be.	I am pretty angry about things these days.	I am angry and hostile about everything.
5	I don't feel particularly hostile at others.	I feel hostile a good deal of the time.	I feel quite hostile most of the time.	I feel hostile all of the time.
6	I don't feel that others are trying to annoy me.	At times I think people are trying to annoy me.	More people than usual are beginning to make me feel angry.	I feel that others are constantly and intentionally making me angry.
7	I don't feel angry when I think about myself.	I feel more angry about myself these days than I used to.	I feel angry about myself a good deal of the time.	When I think about myself, I feel intense anger.
8	I don't have angry feelings about others	It's beginning to make me angry that others are	I feel angry that others prevent me from having	I am constantly angry because others have

	having screwed up my life.	screwing up my life.	a good life.	made my life totally miserable.
9	I don't feel angry enough to hurt someone.	Sometimes I am so angry that I feel like hurting others, but I would not really do it.	My anger is so intense that I sometimes feel like hurting others.	I'm so angry that I would like to hurt someone.
10	I don't shout at people any more than usual.	I shout at others more now than I used to.	I shout at people all the time now.	I shout at others so often that sometimes I just can't stop.
11	Things are not more irritating to me now than usual.	I feel slightly more irritated now than usual.	I feel irritated a good deal of the time.	I'm irritated all the time now.
12	My anger does not interfere with my interest in other people.	My anger sometimes interferes with my interest in others.	I am becoming so angry that I don't want to be around others.	I'm so angry that I can't stand being around people.
13	I don't have any persistent angry feelings that	My feelings of anger occasionally	I am angry to the extent that it interferes with	I'm so angry that I can't make good decisions

	influence my ability to make decisions.	undermine my ability to make decisions.	my making good decisions.	anymore.
14	I'm not so angry and hostile that others dislike me.	People sometimes dislike being around me since I become angry.	More often than not, people stay away from me because I'm so hostile and angry.	People don't like me anymore because I'm constantly angry all the time.
15	My feelings of anger do not interfere with my work.	From time to time my feelings of anger interfere with my work.	I feel so angry that it interferes with my capacity to work.	My feelings of anger prevent me from doing any work at all.
16	My anger does not interfere with my sleep.	Sometimes I don't sleep very well because I'm feeling angry.	My anger is so great that I stay awake 1—2 hours later than usual.	I am so intensely angry that I can't get much sleep during the night.
17	My anger does not make me feel anymore tired than usual.	My feelings of anger are beginning to tire me out.	My anger is intense enough that it makes me feel very tired.	My feelings of anger leave me too tired to do anything.

18	My appetite does not suffer because of my feelings of anger.	My feelings of anger are beginning to affect my appetite.	My feelings of anger leave me without much of an appetite.	My anger is so intense that it has taken away my appetite.
19	My feelings of anger don't interfere with my health.	My feelings of anger are beginning to interfere with my health.	My anger prevents me from devoting much time and attention to my health.	I'm so angry at everything these days that I pay no attention to my health and well-being.
20	My ability to think clearly is unaffected by my feelings of anger.	Sometimes my feelings of anger prevent me from thinking in a clear-headed way.	My anger makes it hard for me to think of anything else.	I'm so intensely angry and hostile that it completely interferes with my thinking.
21	I don't feel so angry that it interferes with my interest in sex.	My feelings of anger leave me less interested in sex than I used to be.	My current feelings of anger undermine my interest in sex.	I'm so angry about my life that I've completely lost interest in sex.